



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

TEXAS SURGICAL CENTER AT MIDLAND

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-16-2246-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

APRIL 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are disputing the non-payment of CPT L8699 for implants used in the procedure."

Amount in Dispute: \$885.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. There are fee guidelines issues. The provider did not submit the necessary original manufacturer's invoice. Although the provider did submit the purchase order within the documentation, the required manufacturer's invoice was not submitted."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|--------------------|---|-------------------|------------|
| September 18, 2015 | Ambulatory Surgical Care for HCPCS Code L8699 | \$885.13 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Section 413.011(b) of the Texas Labor Code sets out the reimbursement guidelines.
3. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 1-In accordance with CMS guidelines, this serviced does not warrant a separate payment.
 - 23-This procedure is not paid separately.

- 18-Duplicate claim/service.

Issues

1. Is the insurance carrier's denial of payment for HCPCS code L8699 supported?
2. Did the requestor certify the actual cost of implantables per 28 Texas Administrative Code §134.402?

Findings

1. On the disputed date of service, the requestor billed CPT codes 28322-RT and L8699. The respondents paid for code 28322-RT and is not in dispute. The respondent reduced payment for code L8699 based upon reason codes "1" and "23."

28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

HCPCS code L8699 is defined as "Prosthetic implant, not otherwise specified."

According to *Addendum BB, Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2015 (Including Ancillary Services for Which Payment is Packaged)*, HCPCS Code L8699 has a payment indicator of "N1".

Addendum DD1, Final ASC Payment Indicators for CY 2015, defines payment indicator o "N1" as "Packaged service/item; no separate payment made."

28 Texas Administrative Code §134.402's preamble states "The Division is adopting minimal modifications to Medicare's reimbursement methodology to reflect use of separate reimbursement for surgically implanted devices in non-device intensive procedures to ensure injured employees have access to care, including surgery where surgically implanted devices are medically necessary."

Section 413.011(b) of the Texas Labor Code states "In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d).The commissioner shall also provide for reasonable fees for the evaluation and management of care as required by Section 408.025(c)and commissioner rules. This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services."

Even though HCPCS code L8699 has a payment indicator of N1, Section 413.011(b) of the Texas Labor Code, 28 Texas Administrative Code §134.402(d), and it's preamble, provide the exception to Medicare's policies and allow separate reimbursement for implantables in non-device intensive procedures. The Division finds the respondent's denial is not supported.

2. 28 Texas Administrative Code §134.402(g)(1)(B) states "A facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable.
(1) The facility or surgical implant provider requesting reimbursement for the implantable shall:
(B) include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge," and shall be signed by an authorized representative of the facility or surgical implant provider who has personal knowledge of the cost of the implantable and any rebates or discounts to which the facility or surgical implant provider may be entitled."
A review of the submitted documentation finds that the requestor did not certify the actual cost of the implantables in accordance with 28 Texas Administrative Code §134.402(g)(1)(B). Also, the requestor did not specify which implantables were billed under code L8699. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

| | | |
|-----------|--|------------|
| _____ | _____ | 04/27/2016 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.